



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 21, 2017

Thair Pond, Administrator
Tomorrow's Hope - Sapphire
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Sapphire, Provider #13G038

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Sapphire, which was conducted on March 16, 2017.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey. Also enclosed is a State form which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2017
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - SAPPHIRE			STREET ADDRESS, CITY, STATE, ZIP CODE 2154 SAPPHIRE PLACE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>Tomorrow's Hope Sapphire is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities for the annual recertification survey conducted from 3/13/17 - 3/16/17.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD</p>	W 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/16/2017
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M 000	<p>16.03.11 Initial Comments</p> <p>Tomorrow's Hope Sapphire is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID)" for the licensure survey conducted from 3/13/17 - 3/16/17.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD</p>	M 000		

Bureau of Facility Standards		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE